



# Implementing an Electronic Medical Record at a Free Medical Clinic

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## BACKGROUND

- Community Outreach INC (COI) offers a free medical clinic which is supported by Samaritan Health Service (SHS) and serves patients who are uninsured.
- SHS ambulatory care pharmacists have offered a diabetes medication management service on a volunteer basis 2-3 days per month at COI since 2003. PGY 1 pharmacy residents provide the same service as a required longitudinal rotation.
- The medication management services provided at COI by pharmacists have been done in paper charts. This poses challenges to proper management of chronic diseases and continuity of care.
- Epic® (an electronic medical record) provides access to patient notes, labs, prescription fills and other medical records from SHS and outside facilities. It also contains a tool for collecting Social Determinants of Health (SDOH) information.<sup>1</sup>
- The Dispensary of Hope (DOH) is a service that provides free access to insulin and currently one GLP-1 receptor agonist (RA) at no cost to the patient or SHS. SHS did not have a good process to access this resource.

## OBJECTIVES

- Implement Epic® and a collaborative drug therapy protocol for diabetes and hypertension for use by the pharmacists at COI.
- Develop a process to access medications from DOH when clinically indicated.
- Collect data on SDOH to better assess the needs of this patient population

## METHODS

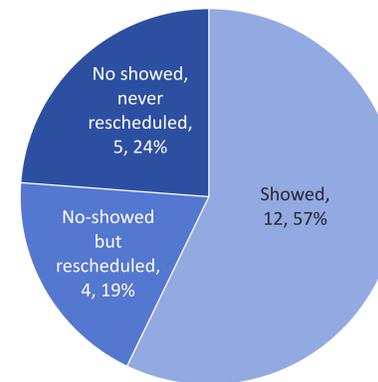
- A grant was secured from the SHS foundation to purchase an EPIC® workstation for COI.
- The chronic disease collaborative practice agreements utilized by pharmacists at the Samaritan Ambulatory Clinics were implemented at COI under the leadership of the medical director Dr. Gabriel Ledger.
- A clinic workflow was developed to reduce the number of patients lost to follow up. Patients with missed visits were offered the option of a telephone visit.
- At each visit, labs and prescriptions were ordered electronically through Epic®.
- The DOH was accessed for patients who would benefit from a GLP-1 RA and those who were on insulin.
- A SDOH questionnaire was done at each initial visit and answers were recorded in Epic.

## RESULTS

### Patients & Attendance

- 21 patients were scheduled for a visit between September 2021 and March 2022.
  - 67% were male, average age was 56, and all were Hispanic or Latino
  - 16 patients (76%) completed an initial visit; 10 scheduled a follow-up visit within the study time frame. All attended their follow-up.
  - Of the 16 patients that were seen, all had Type II Diabetes, 8 (50%) had diabetes and HTN, 1 had peripheral neuropathy, and 1 had stage 3 CKD
- A total of 26 visits occurred: 13 in-person at baseline, 3 via telephone at baseline, 6 in-person follow-up visit, 4 telephone follow-up visits.
- Of the 16 patients that completed a visit, access to outside records showed that 3 were insured and receiving care at another clinic.

Figure 1. Initial Visit Attendance



### Diabetes Outcomes

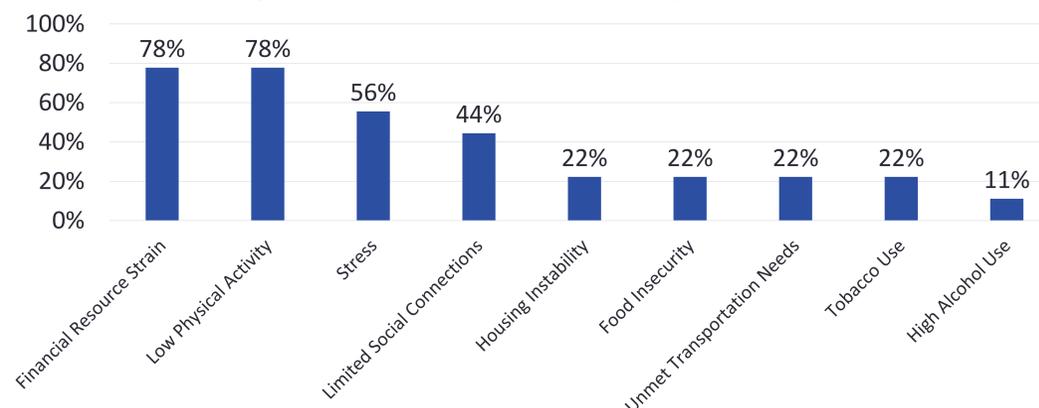
- The mean HgbA1c's collected during the study period was 8.1%, ranging from 5.4% - 10.6%
  - At baseline 9 (56%) had HgbA1c's that were collected ≥ 3 months ago (not up to date). On several occasions the reason for not getting labs was due to lost lab request forms. At follow-up, only 2 patients did not complete labs as ordered.
  - One patient had HgbA1c values tested twice during the study period and improved from 7.9% to 7.3%. Other patients have not yet had an A1c retest, mostly because the 3 month recheck was not yet indicated.
- Through DOH, GLP-1 RA were newly prescribed for 3 patients. Two of these patients reported improved home blood glucose readings at their follow-up visit. One patient was able to discontinue prandial insulin.

### Social Determinant of Health

9 patients had data on SDOH. The top health disparities were:

- Financial resource strain: difficulty paying for food, housing, medical care, and heating.
- Low physical activity: patients frequently reported that the weather made it difficult to engage in physical activity outdoors – reported several times during the winter and rain.
- Stress: Patients reported feeling stressed about their health and their family's health.

Figure 2. SDOH Needs of Patient Population (N=9)



## CONCLUSIONS

- At baseline, patients had high no-show rates, a high rate of uncontrolled diabetes, overdue HgbA1c's, no access to GLP-1 RA, and many SDOH needs.
- We were able to implement several processes to target some of these challenges:
  - Telephone visits** were offered, which brought the follow-up rate to 100%. Expanding this option may help those patients that have unmet transportation needs or insufficient time to drive to an in-person visit.
  - Access to GLP-1 receptor agonists through DOH** allows for better evidence-based therapy to be offered to these patients, with no financial burden to SHS Pharmacy. Access to DOH insulin with the new process is helpful to the SHS medication budget for insulin. With a workflow in place, more patients will get the care needed.
  - The SDOH data** may help identify resources to address health disparities for these patients.
  - EPIC® access** improved continuity of care between the clinic, Samaritan pharmacy and providers, as well as non-Samaritan providers. This improves care and may prevent adverse events and polypharmacy. EPIC® also provided the ability to review clinical notes, assess prescriptions, and order labs and medications without added paperwork.

## FUTURE IMPLICATIONS

- Improve follow-up rates with the ability to manage care telephonically has encouraged the plan to expand this option to all patients.
- The required residency rotation will be adjusted to include phone management.
- Translator services for phone visits will be set up when needed.
- Continuing to collect SDOH data may lead to implementation of resources to target patient's needs.

## REFERENCES

- Nitkin, K. (2019, November 14). A new way to document social determinants of health. Johns Hopkins Medicine, based in Baltimore, Maryland. Retrieved April 3, 2022, from <https://www.hopkinsmedicine.org/office-of-johns-hopkins-physicians/best-practice-news/a-new-way-to-document-social-determinants-of-health>